STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

JOHN ELIAS BALDACCI
GOVERNOR

Brenda M Harvey
COMMISSIONER

Children's Enrollment Form

A completed Referral Packet includes the following:

☐ **Diagnostic Evaluation (24/65M/N)** ☐ **Release of Information (24 only)** ☐**CHAT (24 only)** ☐**Referral Form(65M/N only)**

***Referral Date: _____**

***Type of Services Requested**

☐ Targeted Case Management (MaineCare Section 13.12)
☐ Children's Habilitation Service (MaineCare Section 24)
☐ Treatment Child and Family Behavioral Health Services (MaineCare Section 65M)
☐ Community-Based Treatment for Children without Permanency (MaineCare Section 65N)

Individual Requesting Service: _____Relation to Child: _____

Demographics of Child:

***Child's Name** (spelled as it appears on the MaineCare Card)

*First: *Middle: *Last:

*DOB: *SSN: *Gender: ☐ M ☐ F

*Maine Care #: Race:

***Child's Current Residence (Legal Address)**

*Street:
*Town: *State: ME *ZIP:
*Phone:

Please choose and complete only one of the following guardian types: A, B, or C.

A. Guardian(s)

Parents First & Last Name	Mailing Address	Phone # Cell # ☐ No Phone
Legal Guardian (other than Biological parents)	Mailing Address	Phone # Cell # ☐ No Phone
B. Parental Rights & Responsibilities		
Sole First & Last Name	Mailing Address	Phone # Cell # ☐ No Phone
Shared First & Last Name	Mailing Address	Phone # Cell # ☐ No Phone
Shared First & Last Name	Mailing Address	Phone # Cell # ☐ No Phone
C. State Custody		
DHHS Case Worker First & Last Name	Office Address	Cell # Office # Pager#

***DSM-IV WRITTEN DIAGNOSIS AND NUMBER CODE**
(Not necessary to complete if accompanying a 65M/N Referral Form)

Axis I: _____

Axis II: _____ Axis III: _____

Axis IV: _____ Axis V: _____

***Disability Category**

MR/AUTISM: ☐ MH: ☐ SA: ☐ EI/DD: ☐(Targeted Case Management Use Only)

Description of Identified Need: (Not necessary to complete if accompanying a 65M/N Referral Form)

Please review the following services and check off those, which are currently provided or have been in the past.

Service	Current	Past	Provider	Frequency	Duration	Active Yes or No	Beneficial Yes or No
Psychiatry/Med Mgt.							
Outpatient Tx.							
Hospital							
Mobile Crisis							
Family Therapy							
Home Based Services							
Partial Hospital Program/IOP							
Crisis Unit							
Residential Tx.							
Other							

Name of Person Completing this Form: Title:

Agency:

Office Location/Address:

Phone Number: Fax Number: Date: